

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-028130

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4222 STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED AUG 14 1963

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in 1b <b>38 YEARS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>623 EUCLID AVENUE LEWELLYN NURSING HOME</b>		d. STREET ADDRESS (If outside, give location) <b>4908 WOODLAND AVENUE</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>JESSE PEARL BANISTER</b>			4. DATE OF DEATH Month Day Year <b>JULY 27 1963</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/21/1882</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUILDER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RAY COUNTY MISSOURI</b>		
11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		

13a. FATHER'S NAME <b>JAMES WILLIAM BANISTER</b>	13b. MOTHER'S MAIDEN NAME <b>ANNIE ELIZABETH JOHNSON</b>	14. NAME OF HUSBAND OR WIFE <b>MRS. DAISY MAE BANISTER</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>5430 LYDIA AVENUE KANSAS CITY, MO.</b>	17. INFORMANT <b>MRS. W. E. YANCEY</b>

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Cerebro Vascular accident</b> DUE TO (c) <b>Artero Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Kansas City, Jackson, Missouri</b>		20f. CITY, TOWN, OR LOCATION <b>Kansas City, Jackson, Missouri</b>	
21. I attended the deceased from <b>May 15 1963</b> to <b>July 27-63</b> and last saw him alive on <b>July 26-1963</b> Death occurred at <b>9:10 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James C. Walker M.D.</b>		22b. ADDRESS <b>2727 Main, R.C. 8 Mo</b>	22c. DATE SIGNED <b>July 27-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JULY 29, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>COWGILL CEMETERY</b>	23d. LOCATION (City, town, or county) <b>COWGILL MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS, 1331 BRUSH CREEK, KANSAS CITY, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>7-29-63</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

JAMES C. WALKER MEDICAL CERTIFICATION

VS 300 Rev. 4/59	DATE AMENDED
1	
2 3758	
3	
4 0	
5 2	
6	
7 0	
8 2	
9 331X	
10	
11	
12 86-0	
13	

W. James Charles Walker  
2nd floor - 2727 Main Street  
1:00-5:00  
0 2 0 4  
0-00

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*W. James Charles Walker*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.